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ABSTRACT

Hypnosis is an increasingly popular clinical intervention. The number of training courses in hypnosis is growing each year. Research on hypnosis training appears to show that limited exposure to training, as is typical in the common 3 to 5 day format of mass training, produces limited results. Only when training is extended over time do the results alter. Limited training is in part the artifact of the availability of continuing education and its costs. However, it is also the result of a conceptual muddle about the purpose of clinical training in hypnosis and the very nature of hypnosis in treatment. Hypnosis is sometimes viewed as a technique, sometimes as a strategy, and sometimes as a treatment. Clinical hypnosis and hypnotherapy are best thought of as akin to family therapy. Clinical hypnosis is more of a professional culture and epistemological point of view than a technique, strategy or a treatment. Clinical hypnosis should be taught at a level that will provide the possibility of beginning clinical mastery. This requires on-going training beyond the workshop experience. Adequate training in the systematic application of hypnotherapy as a treatment approach is mandatory if psychologists are ever to be able to assess the clinical efficacy of hypnotically-framed therapeutic interventions. Systematic application of an approach can only develop from the basic mastery of a clinical skill. (Author/NRB)

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CLINICAL MASTERY OF HYPNOSIS

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APA Symposium: On The Teaching of Hypnosis

Billie Strauss, Ph.D., Chairman

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Presented at the 93rd Annual Convention of The American Psychological Association

Los Angeles, California, August 1985

CLINICAL MASTERY OF HYPNOSIS

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Abstract

Hypnosis is an increasingly popular, clinical intervention. The number of training courses in hypnosis is growing each year. Research on hypnosis training appears to show that limited exposure to training, as is typical in the common 3-5 day format of massed training, produces limited results. Only when training is extended over time do the results alter. Limited training is in part the artifact of the availability of continuing education and its costs. However, it is also the result of a conceptual muddle about the purpose of clinical training in hypnosis and the very nature of hypnosis in treatment. Hypnosis is sometimes viewed as a technique, sometimes as a strategy, and sometimes as a treatment. In this paper it is suggested that clinical hypnosis and hypnotherapy is best thought of as akin to family therapy: it is more of a professional culture and epistemological point of view rather than a technique, strategy or a treatment. The implications of this point of view for training are considered.

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In a random study of the general membership of APA reported by Taft and Rodolfa in 1982, just under half of the psychologists reported having received training in hypnosis. Almost all responded favorably to items regarding the clinical value and scientific validity of clinical and experimental hypnosis (Taft & Rodolfa, 1982).

While attitudes toward hypnosis, particularly among those who have had training in hypnosis, remain highly favorable over time, actual patterns of use are very different. Of those trained, 12% never actually applied hypnosis, 65% do not currently use hypnosis at all, and another 25% reported a monthly frequency range of 1 to 15 times per month. Thus a virtual 80% of those psychologists who have been trained in hypnosis do not or scarcely ever utilize hypnosis despite retaining strongly positive attitudes.

Why is this the case? Among the sample studied by Taft and Rodolfa, almost all received their training at a post-graduate level either during internship or at continuing education workshops averaging 20 hours of training. This is equivalent to the basic or introductory level workshops offered throughout the country. Drop-out rates at this level of training are extremely high. The numbers are different when training levels are higher. Taft and Rodolfa's comparison sample drawn from Division 30 membership lists (prior to the change in membership criteria) showed higher levels of training and dramatically but vastly higher utilization rates.

When I studied post-training change among participants in the Advanced Courses in Clinical Hypnosis offered by Division 30 of the

American Psychological Association (Psychological Hypnosis) in 1983 and 1984, I found generally confirming data. All participants had at least one prior course in hypnosis, and many had five or six such courses. One and two years after the conclusion of the workshop, 70% of all respondents reported either increased frequency or increased quality in their work with hypnosis. None reported decreases. This is particularly interesting because it is uncorrelated with workshop satisfaction reports and was measured and thus not confounded with a "workshop high" effect. Of this already advanced group, 50% indicated that they would likely avail themselves of further supervision in hypnosis.

It is not possible to assert that by itself more training leads to higher utilization rates. It is quite conceivable that this data represents the mere sampling bias that the small subsample who are most enthusiastic about hypnosis and most inclined to use it clinically are the ones who go on to further training. However, since both hypotheses have a common sense ring-of-truth to them, it seems reasonable to assume that both are operating.

It may not just be the amount of training but how the training occurs that is the decisive factor. Pulver and Pulver (1975) did a follow-up study on physicians and dentists trained in hypnosis at the University of Pennsylvania Hospitals over a 12-year period. They found much higher utilizations rates than Taft and Rodolfa. While some of this may well be due to differences between physicians (and dentists) and psychologists, some appears to be due to on-going supervision, modeling and learning in training that incorporated weekly sessions over

a ten-week period following the initial intensive workshop experience. That is, massed practice in the learning of hypnotic skills is not as useful as distributed practice. It is basic to Gestalt learning principles: learning with understanding yields higher retention rates than rote learning.

Low rates of utilization from the typical training workshop format are not suprising. Clinical hypnosis is too complex a skill to master and integrate within two or three days. Although the formulae used on hypnosis are varied, they are not complex. They can be learned readily by most clinicians in a few days time. However, this is not the criterion for learning a clinical skill. A more reasonable criterion, on a basic leave, would be the ability to evaluate appropriate candidates and situations for the use of simple hypnotic procedures and the ability to carry through that intervention successfully. This requires a soundness of judgement, a comfort of execution and a reasoned understanding of how the hypnotic intervention is integrated into an overall treatment plan. Anything short of this cannot be considered mastery at a beginning level.

Until a level of comfort associated with mastery can be reached, anxiety, apprehensiveness, uncertainty, hesitation, overenthusiasm, mis-attribution of "failure", are all such important factors that they act as aversive counter-conditioners. Only the hardy or the reckless are bound to survive. These emotional factors and simple learning factors tend to be ignored.

Hypnosis appears to engender the most astonishing naivete among otherwise sophisticated people. Attention paid in most introductory

level courses to the trait/talent dimension of hypnotizability and to differential responses of individuals does little to dispel the magical powers attributed to hypnosis and the hypnotists. The experience of having classical hypnotic phenomena elicited is exciting and "magical". Students at beginning and intermediate levels are typically focused on concerns about putting clients into trance, anxiety about what to do if "it" doesn't work, worried about the wording of trance inductions as though they were secret spells that might not work if the wording were improper.

Important issues in the development clinical mastery of the skills of hypnosis cannot adequately be addressed by didactic means. They can only be addressed by adequate training. This requires time, sufficient experience, and careful, consistent monitoring of skills development by competent senior trainers. It is perceptual knowledge, in Herbert Simon's sense that is required (Simon, 1985). Expert knowledge is defined as knowing which cues to look for and, when they are present, in making applications. They are not formulae.

While few would disagree with this point, training in hypnosis does not meet this criterion. Although The Society for Clinical and Experimental Hypnosis, The American Society of Clinical Hypnosis, International Society of Hypnosis, and now Division 30, all offer training in hypnosis, none of these societies trains trainers, certifies or lists trainers, has minimum standards of training, assesses post-training competencies, or has any way whatsoever of either maintaining standards or alternatively, taking an aggressive responsible position to follow-up and follow through.

The difficulties are in part political, but they are also conceptual.

Hypnosis is generally taught as a set of techniques or procedures to be applied in various ways. As Frischholtz and Spiegel (1983) point out, it is confusing and illogical to teach hypnosis as a technique and the to evaluate it as a treatment. Since hypnosis is always used within the context of a treatment format or within a larger treatment format, they conclude that to be consistent, we should consider hypnosis and hypnotherapy a technique, not a treatment or treatment strategy.

Although this position is logical, it doesn't fit the paradoxical and unusual world of clinical hypnosis where a significant number of clinicians not only apply hypnosis as a specific technique but do therapy and provide treatment they call hypnotherapy. In fact, among those who do what they call hypnotherapy, hypnosis and more formal trance induction are done rather less then more (e.g., Brown & Fromm, 1986; Erickson, 1965).

Hypnotherapy is like family therapy. It is an approach to treatment, an orientation to problem solving, a way of perceiving, not a treatment per se. Family therapy is a "movement" of multi-disciplinary professionals of different theoretical orientation within the world of psychotherapy. Family therapists have more in common by adherence to family therapy models than in their respective allegience to psychoanalysis, systems therory or any other philosophical model. They have their own professional societies, journals and models of training, diplomate programs, etc. They represent an internally self-referential cohesive discipline.

Hypnosis is a professional culture quite similar to family therapy

although significantly smaller, more tradition-bound, and with less pervasive influence on the world of psychotherapy as a whole. Hypnotherapy exists in the same way that family therapy exists: It is an overriding approach to treatment and a model for treatment that subsumes other existing therapeutic treatment models without replacing them. Hypnosis is largely a rhetorical intervention that attempts to change individual psychological problems, physiological responses and even family dynamics through the manipulation of symbols and images, the recruitment of novel cognitive and physiological responses, and the engagement and misdirection of attention. Clinical hypnosis is not a technique but an extraordinarily complex set of clinical skills. I believe that it is this inherent complexity that introductory level students implicitly respond to with so much anxiety. We have virtually no standards of training, no system for developing a model of training or no system other than self-advertisement for promoting on-going training and the existence of a diplomate status.

Clinical hypnosis should be taught at a level that will provide the possibility of beginning clinical mastery. This requires on-going training beyond the workshop experience, most reasonably in a group supervision format. Training in family therapy has received much greater attention than training models in hypnosis. Given the similarities, the various family therapy are a good place to begin for training in hypnosis.

There is a good deal more at stake here than resolving conceptual confusions, allaying trainee anxiety or reducing high drop-out rates. Adequate training in the systematic application of hypnotherapy as an

approach to treatment, irrespective of various styles within the hypnosis community, is mandatory if we are ever to be able to assess the clinical efficacy of hypnotically-framed therapeutic interventions. Only through systematic training can we attain the "hidden variable" in therapy outcome--the therapist. In our field, as Lazar and Dempster (1984) pointed out, we know virtually nothing about this variable. Lester Luborsky and his group (Luborsky, et al, 1985) reported an interesting, germaine finding. They compared therapists trained in Beck's form of cognitive behavior therapy, therapist's trained in the short-term psychodynamic psychotherapy developed at the Menninger Foundation, and counselors trained in drug counseling in terms of effectiveness in treating patients in a Methodine maintenance program. All the treatment was manual-based and all the therapists and counselors had extensive training. All sessions were taped and rated according to a "purity" measure, i.e., the degree of systematic application of the treatment form to be assessed. Briefly, what they found was that both CBT and SET therapists' patients did much better than simple counseling patients. However, throughout the study, some therapists did much better than others, irrespective of orientation. There was a simple finding, the more consistently and systematically the therapist approached treatment from his or her orientation, the better the therapeutic outcome.

The investigation of therapist variables in psychotherapy is just beginning. I suspect that Luborsky's findings will hold up. I suspect that these same findings would emerge from studying the work of

therapists who utilize a hypnotherapeutic approach. Systematic application of an approach can only develop from the basic mastery of a clinical skill.

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